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Summary of 2003 Workers' Compensation Reform Legislation

In 2003, the State Legislature passed reforms to California's workers' compensation system in response to the "crisis" of increasing costs and premiums. This crisis developed as a result of a confluence of factors during the ten years following the repeal of the state's minimum rate law: (1) fierce price competition developed among insurers; (2) steadily increasing health care costs; (3) statutory expansion of workers' compensation benefits; (4) utilization of medical services by California claimants vastly exceeded the national average; (5) premiums being charged below the amount paid out for claims; (6) the insolvency of dozens of insurance companies became insolvent and the abandonment of the California market by other insurers; (7) the increasing market share of the State Compensation Insurance Fund; (8) the financial impact on CIGA, the entity created to pay the claims of insolvent insurers; and (9) the eventual crisis of skyrocketing premiums paid by California businesses, which are among the highest in the nation.

The 2003 reform legislation addresses three main areas of concern identified by the Legislature: (1) providing CIGA with the resources to continue paying the claims of insolvent insurers; (2) reducing costs in the workers' compensation system (mostly through control of medical costs and prevention of over-utilization of medical services); and (3) attempting to ensure that insurance companies pass the cost savings on to employers.

CIGA & INSOLVENCY

As a result of low premiums and increasing health care costs, many workers' compensation insurers became insolvent. The California Insurance Guaranty Association (CIGA) is directed by statute to pay the claims of insolvent insurers. In the last several years, CIGA has paid out more in claims to injured workers than it has collected in surcharges from the solvent insurers. The 2003 reform legislation makes the following attempts to address CIGA's cash flow issues:

- The California Infrastructure and Economic Development Bank may issue bonds on behalf of CIGA to finance the costs of claims of insolvent workers' compensation insurers. (A.B. 227, Gov. Code §§ 63049.62, 63049.64, 63071.)

- Expands the statutory definition of "insolvency" to include: "an inability of the insurer to meet its financial obligations when they are due." Prior to the reform legislation, insolvency was only defined as "any impairment of minimum paid-in capital." The change should make it easier for CIGA to place troubled insurers into receivership before they are completely bankrupt. (A.B. 227, Ins. Code § 985.)

- Allows for Special Assessments against solvent workers' compensation insurers to repay the bonds; retains current rules allowing surcharge to insureds. (A.B. 227, Ins. Code §§ 1063.14, 1063.145, 1063.74.)

- Provides that a maximum of $1.5 billion in bonds may be outstanding at anytime, that all bonds must be issued prior to Jan. 1, 2007, and provides that all bonds shall have a final maturity of twenty years or less. (A.B. 227 Ins. Code § 1063.75.)

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egislature determined that workers' compensation premiums could be significantly control measures were put into place. Significantly, the Legislature found that rs in California paid more for similar medical services and utilized those services at than comparable injured workers in other states. The 2003 reform legislation eral provisions designed to control costs in the system:

BATING FRAUD

ses the fine for workers' compensation fraud from $50,000 or double the value of raud to $150,000 or double the value of the fraud, whichever is greater. (A.B. 227, ode § 1871.4.)

fies adoption of new fraud protocols and requires insurers, employers, strators, attorneys, administrative law judges, and everyone else to report all od workers' compensation fraud. (S.B. 228, Labor Code §§ 139.4, 139.45.)

ATIONAL REHABILITATION BENEFIT

sections dealing with vocational rehabilitation and adds a new section providing sferable vouchers in amounts from $4,000 to $10,000 to be used for "education-related retraining or skill enhancement." Applies to injuries on or after Jan. 1, 2004. 227, Labor Code §§ 139.5, 4658.5, 4658.6.)

3. LIMITATION ON PHYSICAL THERAPY / CHIROPRACTOR VISITS

thstanding any other provisions, "an employee shall be entitled to no more than 24 actic and 24 physical therapy visits per industrial injury." (S.B. 228, Labor Code 4604.5(d).)

DICAL TREATMENT UTILIZATION GUIDELINES

missions a study of "evidence-based, peer-reviewed nationally recognized standards of care, including existing medical treatment utilization standards . . . for the purpose of the adoption of a medical treatment utilization schedule." (S.B. 228, Labor Code § 77.5.)

- Requires the adoption of a medical treatment utilization schedule on or before Dec. 1, 2004. (S.B. 228, Labor Code § 5307.27.) Provides that upon adoption of a utilization schedule, such schedule shall be "presumptively correct on the issue of extent and scope of medical treatment" unless rebutted "by a preponderance of the evidence." (S.B. 228, Labor Code § 4604.5(a), 5307.27.)

- Until a utilization schedule is adopted, the American College of Occupational and Environmental Medical Practice Guidelines are deemed presumptively correct unless rebutted by a preponderance of the evidence. (S.B. 228, Labor Code § 4604.5(c).)

- If a particular injury is not listed in the schedule or in the Practice Guidelines, "authorized treatment shall be in accordance with other evidence based medical treatment guidelines generally recognized by the medical community." (S.B. 228, Labor Code § 4604.5(g).)

- Requires every employer to "establish a utilization review process" governed by written policies and procedures that ensure decisions are based on the "medical necessity to cure and relieve" and are "consistent with the schedule for medical treatment utilization." (S.B. 228, Labor Code § 4610.)

5. MEDICAL FEE SCHEDULE / CAPS TO MEDICARE, INCLUDING OUTPATIENT SERVICES

- Repeals the current medical fee schedule procedures, and replaces it with a new Section requiring the adoption and periodic revision of "an official medical fee schedule that shall establish reasonable maximum fees paid for medical services." (S.B. 228, Labor Code § 5307.1.) Outpatient services will now be included in the schedules. (Id.)

- Provides that all fees shall comply with the "structure and rules" of the relevant Medicare and Medi-Cal payment systems. (Id.)

- Caps maximum reasonable fees at 120 percent of Medicare. Provides that if a procedure is not listed on the schedule or in Medicare, the maximum fee shall not exceed 120 percent of Medicare for services that require comparable resources. (Id.)

- Until a new medical fee schedule is adopted, "the maximum reasonable fee paid shall not exceed the fee specified in the official medical fee schedule in effect on December 31, 2003." (Id.)

- Commissions an annual study "of access to medical treatment for injured workers." Allows adjustments to medical fees based upon the study, and allows for increases to above 120 percent of Medicare if "substantial access problems exist." (S.B. 228, Labor Code § 5307.2.)

6. PRESCRIPTION DRUG PRICE CAP

- Caps drug prices at 100 percent of fees provided in the Medi-Cal payment system. Provides that if a drug is not listed on the schedule or in Medi-Cal, the maximum price shall not exceed 100 percent of comparable Medi-Cal listed drugs. (S.B. 228, Labor Code § 5307.1.)

- Requires "any person or entity that dispenses medicines and medical supplies" to dispense the generic equivalent except in limited circumstances. (Prior law applied the requirement only to pharmacies.) (S.B. 228, Labor Code § 4600.1.)

7. ROLL-BACK OF FEES FOR PHYSICIAN SERVICES

- Rolls-back all fees for physician services during calendar years 2004 and 2005 by 5% of the rate currently in effect, and allows for further reductions to a maximum reduction equal to the Medicare rate. (S.B. 228, Labor Code § 5307.1(k).)

8. REPEAL OF THE TREATING PHYSICIAN PRESUMPTION

- Repeals the treating physician presumption and replaces it with a new presumption that applies only in limited circumstances. "In all other cases . . . regardless of the date of injury, no presumption shall apply to the opinion of any physician on the issue of extent and scope of medical treatment, either prior or subsequent to the issuance of an award." (S.B. 228, Labor Code §§ 4062.9, 4604.5(e).)

RATE / PREMIUM PROVISIONS

Media reports suggest there was much debate in committee over whether to give the Insurance Commissioner the power to regulate the rates offered by workers' compensation insurers. The final legislation does not include any such provisions, but the 2003 reform legislation does include provisions designed to pass any cost savings from the reforms on to employers. Detailed below are the insurer rate / premium provisions:

- Requires the Insurance Commissioner to "take into account the projected savings" from the legislation in determining "the advisory pure premium rates" for policies beginning or renewed on or after Jan. 1, 2004. (A.B. 227, Ins. Code § 11735.1(a).)

- Specifies that "Insurers shall file rates . . . that include the provision for projected savings determined by the insurance commissioner . . . ." (A.B. 227, Ins. Code § 11735.1(b).)

- Requires that rates nonetheless must comply with Section 11732, which provides that rates shall not be "inadequate," "unfairly discriminatory," or tend to create a monopoly. (Id.)

- Provides that "this Section" shall remain in effect only until Jan. 1, 2005. (A.B. 227, Ins. Code § 11735.1(c).)

- Changes do not give the Commissioner the authority to disapprove rates that are "excessive." As before the 2003 reforms, the Commissioner may only disapprove rates that are inadequate, unfairly discriminatory, tend to create a monopoly, or that do not meet the technical filing requirements. (Ins. Code § 11732 et seq.)

- Requires the WCIRB to "determine the cost savings" achieved by this legislation. (A.B. 227, Ins. Code § 11742(d).)

- Requires each insurer to "certify" that its rates reflect the cost savings determined by the WCIRB. (Id.)[1]

- Requires the Commissioner to post on the Insurance Department's web site a comprehensive insurance rate comparison for the top 50 workers' compensation insurance companies. (A.B. 227, Ins. Code § 11742(b).)

- Commissions a study and report into "the feasibility of reinstating a minimum rate regulatory structure for the workers' compensation insurance market, to be phased in over a five-year period." (A.B. 227, at SEC. 17(c).)

- Requires the Commissioner to "study and analyze the financial condition, underwriting practices, and rate structure of the State Compensation Insurance Fund" for a report "on the potential of reducing rates by July 1, 2004, and every July 1 thereafter." (S.B. 228, at SEC. 52.5(b).)

MISCELLANEOUS PROVISIONS

A number of other significant reforms were included in the 2003 reform legislation. Some of them are mentioned below:

1. COLLECTIVE BARGAINING TO INCLUDE WORKERS' COMP.

- Repeals special collective bargaining rules with respect to aerospace and timber employers and adds a new section allowing collective bargaining agreements to contain workers' compensation terms for all employers over a certain size. Further requires annual reports regarding all labor-management agreements. (S.B. 228, Labor Code § 3201.7.)

2. OBJECTIONS TO MEDICAL TREATMENT DETERMINATIONS

- Rewrites the procedure for objections to medical determinations, including how to seek agreements on treatment with injured workers who are and are not represented by counsel. All disputes require a physician report to resolve, and such reports are expressly admissible in further judicial proceedings. (S.B. 228, Labor Code § 4061.)

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[1] The requirement that insurers certify rates according to the WCIRB's determination of the cost savings is arguably inconsistent with the requirement that they "shall file" rates that "include the provision for projected savings" determined by the Commissioner.

- Provides a carve-out for spinal surgery, which now requires a second opinion from an orthopedic surgeon to resolve the disputed surgical recommendation. (S.B. 228, Labor Code § 4062(b).) The spinal surgery carve-out expires on Jan. 1, 2007. (S.B. 228, Labor Code § 4062(h).) Commissions a study of the spinal surgery second opinion procedure to be completed by June 30, 2006 to make recommendations for further legislation. (S.B. 228, at SEC. 48.)

- Specifies that relevant portions of "medical treatment protocols published by medical specialty societies" shall be admissible in appeals board proceedings. (S.B. 228, Labor Code § 5703.)

3. INSURER'S REPORT OF EMPLOYERS' INJURY PREVENTION PROGRAM

- Requires every insurer to conduct a review and written report "of the injury and illness prevention program (IIPP) of each of its insureds within four months of the commencement of the initial insurance policy term." (S.B. 228, Labor Code § 6401.7(*l*).)

- Section 6401.7(l) imposes on insurers an obligation to conduct a "review" of each new insured's IIPP within four months of initial policy inception. The review must include a determination of whether the insured has implemented all required IIPP components, and an evaluation of the IIPP's effectiveness. The reviewer must prepare a written report specifying the findings and recommended changes deemed necessary to make the IIPP effective. The reviewer must be an independent professional licensed engineer, certified safety professional, or certified industrial hygienist. (Id.)